

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pininsula General Hospital</u>		d. STREET ADDRESS <u>Locust St.</u>		
3. NAME OF DECEASED (Type or print) <u>Mary Allen</u>		4. DATE OF DEATH <u>May 27 1961</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 2, 1874</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		
13. FATHER'S NAME <u>U.S. A.</u>		14. MOTHER'S MAIDEN NAME <u>U.S. A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>U.S. A.</u>		16. SOCIAL SECURITY NO. <u>U.S. A.</u>		
17. INFORMANT <u>U.S. A.</u>		Address <u>U.S. A.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 904.0 DUE TO (b) <u>Fracture Lt. Femur.</u> Conditions, if any, which gave rise to immediate cause (c) <u>904.0</u> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes Mellitus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>X</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall at home</u>		
20c. TIME OF INJURY Month, Day, Year <u>9:00 5-16 1961</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home.</u>		20f. (City or town) <u>Snow Hill Worcester Md</u> (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <u>Phyllis A. Insley</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Phyllis A. Insley</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5-27-61</u>		
Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/1/1961</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany</u>		22d. LOCATION (City, town, or country) (State)		
23. FUNERAL DIRECTOR <u>Clinton F. Stewart Salisbury Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>		
ADDRESS		24b. REGISTRAR'S SIGNATURE		

RECEIVED  
MAY 1941  
(M)

(1)

MALE  
MEDICAL  
CERTIFICATE OF DEATH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
DISEASE  
SIGNED  
DATE

*Handwritten text, mostly illegible due to bleed-through from the reverse side of the page.*

## CERTIFICATE OF DEATH

Reg. Dist. No. 06168

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Fruitland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND BOBBY ALLEN</u>		4. DATE OF DEATH Month Day Year <u>MAY 25 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 19, 1908</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>3 8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Sidney Allen</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Woodleaf</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT Mr. Bobby Ray Allen (Son) Address Fruitland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>uemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>He suffered from cardiovascular disease</u> DUE TO <u>cardiovascular</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>unclear</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>5-16</u> , 19 <u>61</u> , to <u>5-25</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5-25</u> , 19 <u>61</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilbur R. Ellis Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>5-25-61</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Wilbur R. Ellis Jr. - Medical Center - Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 1, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Bridge Cemetery</u>	22d. LOCATION (City, town, or county) <u>Henderson, North Carolina</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>MAY 29 '61</u> DATE _____	24b. REGISTRAR'S SIGNATURE <u>Wilbur R. Ellis</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

July 1, 1961 Book Bridge Company, Henderson, North Carolina

Dr. William R. Ellis Jr. - Medical Center - Baltimore, Maryland

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## CERTIFICATE OF DEATH

Reg. Dist. No. 06169

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>6 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS <u>WEST ST</u>		23 X-2	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George William Aydelotte</u>				4. DATE OF DEATH Month Day Year <u>MAY 13 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 16, 1914</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD RFD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHICKEN CATCHER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>POULTRY</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD RFD</u>	
13. FATHER'S NAME <u>THOMAS AYDELOTTE</u>				14. MOTHER'S MAIDEN NAME <u>META AYDELOTTE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>28-20-6588</u>		INFORMANT Address <u>MRS GEORGE W. AYDELOTTE BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous Subarachnoid Hemorrhage</u> 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>5 da.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-8</u> , 19 <u>61</u> , to <u>5-13</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5-13</u> , 19 <u>61</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter D. Ellesht</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Md. 5-14-61</u>			
PHYSICIAN'S NAME (Type) <u>Anna A. Burboys</u>				ADDRESS <u>Berlin Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/16/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>PITTSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burboys</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 16 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpse papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

1  
FOR STATE  
HEALTH DEPT.

6183  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frankford</u> <u>Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Route # 66</u>	
3. NAME OF DECEASED (Type or print) <u>Archie Allen Baker</u>		4. DATE OF DEATH <u>5-11-61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <u>X</u>	8. DATE OF BIRTH <u>12-26-39</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Officer</u>		11. BIRTHPLACE (State or foreign country) <u>Selbyville, Del.</u>	
13. FATHER'S NAME <u>Manford Baker</u>		14. MOTHER'S MAIDEN NAME <u>Addie Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>222-24-4227</u>	
17. INFORMANT <u>Earl L. Royer, M.D.</u>		Address <u>407 Camden Ave. Salisbury, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>X</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of car that ran off road.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3:05 P.M.</u> <u>5-8-61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <u>X</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway #66</u>		20f. (City or town) <u>Frankford</u> (County) <u>Sussex</u> (State) <u>Del.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> <u>X</u> , Inquiry <input checked="" type="checkbox"/> <u>X</u> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> <u>X</u> , Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>5-14-61</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>X</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>5-14-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mechanics</u>		22d. LOCATION (City, town, or country) (State) <u>Millsboro Del.</u>	
23. FUNERAL DIRECTOR <u>Henry W. Watson</u>		24a. REC'D BY REGISTRAR <u>May 18 '61</u>	
ADDRESS <u>Pocomoke City, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FBI - NEW YORK

NY 100-100000

(1)

Henry W. Jackson, Nashville, Del.

Mr. J. Edgar Hoover, Director, FBI

-10-11-

1:00 P.M. - 11-11-61

Arrived at New York City, 11-11-61

1:00 P.M. - 11-11-61

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## CERTIFICATE OF DEATH

Reg. Dist. No.

06171

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>Rural Princess Anne Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>19X-2</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>William Harold</u> First Middle Last				4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 30, 1898</u>	
9. AGE (In years lost birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>former</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Henry Bedsworth</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Tyler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>		17. ADDRESS <u>Louise Bedsworth Princess Anne R#3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism due to Thrombophlebitis</u> DUE TO (b) <u>464X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-8</u> , 19 <u>61</u> , to <u>5-12</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5-12</u> , 19 <u>61</u> , and that death occurred at <u>11:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William B. Edgell</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>5-14-61</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/15/61</u>		<u>Griggle</u>		<u>Princess Anne</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Armed Herman Princess Anne</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAY 18 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

NAME OF DECEASED *William Smith*  
AGE *30*  
RESIDENCE *100 West 10th St. New York City*

DATE OF DEATH *Sept 30, 1911*  
PLACE OF DEATH *Home*  
CAUSE OF DEATH *Heart Disease*

DECEASED WAS *Single*  
MARRIED *No*  
BORN *Sept 10, 1881*  
PLACE OF BIRTH *New York City*

DECEASED WAS *Single*  
MARRIED *No*  
BORN *Sept 10, 1881*  
PLACE OF BIRTH *New York City*

DECEASED WAS *Single*  
MARRIED *No*  
BORN *Sept 10, 1881*  
PLACE OF BIRTH *New York City*

DECEASED WAS *Single*  
MARRIED *No*  
BORN *Sept 10, 1881*  
PLACE OF BIRTH *New York City*

## CERTIFICATE OF DEATH

Reg. Dist. No. **06172**

6185

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>511 MARKET STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARGARET LUCUS Bowen</b>				4. DATE OF DEATH Month Day Year <b>May 5 - 5 - 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 1 1877</b>	
9. AGE (In years, lost birthday) <b>83 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>OLIVER J. LUCUS</b>			
14. MOTHER'S MAIDEN NAME <b>EMMA W. MATTHEWS</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>—</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT Address <b>MRS S. M. CROCKETT, 410 MARKET ST. POCOMOKE CITY, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>Essential Hypertension</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential Hypertension</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/2</b> , 19 <b>61</b> to <b>5/5</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>5/5</b> , 19 <b>61</b> , and that death occurred at <b>10:55 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David J. Gilmore</b>				ADDRESS (Street, city or town, state) <b>Salisbury Md</b> DATE SIGNED <b>5/5/61</b>			
PHYSICIAN'S NAME (Type) <b>DAVID J. GILMORE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-7-61</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>BETHANY METHODIST</b>		22d. LOCATION (City, town, or county) (State) <b>POCOMOKE CITY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert N. Watson</b> ADDRESS <b>Pocomoke City, MD.</b>				24a. REC'D BY REGISTRAR <b>MAY 8 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

185

M

Decedent's Name: [illegible]

Place of Birth: [illegible]

Age: [illegible]

Sex: [illegible]

Date of Death: [illegible]

Place of Death: [illegible]

Cause of Death: [illegible]

Signature of Physician: [illegible]

Signature of Coroner: [illegible]

Signature of Registrar: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Decedent's Name: [illegible]

Place of Birth: [illegible]

Age: [illegible]

Sex: [illegible]

Date of Death: [illegible]

Place of Death: [illegible]

Cause of Death: [illegible]

Signature of Physician: [illegible]

Signature of Coroner: [illegible]

Signature of Registrar: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

## CERTIFICATE OF DEATH

Reg. Dist. No. 06173

6186

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Haven</b>				c. LENGTH OF STAY IN 1b <b>3 wks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oriole</b>			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>R. Bozman</b> Last				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 23, 1876</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Jones</b>				14. MOTHER'S MAIDEN NAME <b>Mary Windsor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Van Muir Monie, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>444X</b> DUE TO <b>myocardial failure of compensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis - hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>2-3 wks</b> <b>2-3 mo.</b> <b>5 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20f. (County)		20f. (State)	
21. I certify that I attended the deceased from <b>5/1</b> , 19 <b>61</b> , to <b>5/15</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>5/15</b> , 19 <b>61</b> , and that death occurred at <b>4</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Barbara Hunt, Md.</b> DATE SIGNED <b>5/16/61</b>							
ACTUAL SIGNATURE <b>Barbara Hunt</b> M.D.				PHYSICIAN'S NAME (Type) <b>Barbara Hunt</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-17-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oriole Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oriole, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levin R. Wilson</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 22 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6187

06174

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron (Rural)</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>H.D.# 1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>THOMAS</b> Last <b>BYRD</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>10th</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1878</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>21</b>	
11. IF UNDER 24 HRS. Hours <b>0</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Quantico, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Thomas James Byrd</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Cooper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Mrs. Minnie E. Byrd (Wife)</b>		Address <b>R.D.#1 Hebron, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Previous cerebral hemorrhage - hemiplegia</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/1</b> 19 <b>58</b> to <b>death</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5/9</b> 19 <b>61</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Ernest Larnore</b>		22b. DATE <b>May 12 / 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Ernest M. Larnore</b>		22d. ADDRESS <b>Delmar, Delaware</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 12, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Quantico Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Quantico, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>MAY 16 '61</b>	
ADDRESS <b>SALISBURY, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Dalhousie E. Harris</b>	



1912

CENTRAL OF TEXAS

Station

Station

Station (New)

Station (New)

1912

1912

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6188 CERTIFICATE OF DEATH 06175											
Item 9 File 6288 6/23/61											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>3Mos. 1Day</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>R.D.#5 Pemberton Drive</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Wesley Carter</u>				4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1961</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 25, 1869</u> <u>92</u> yrs.		9. AGE (In years last birthday) Months <u>2</u> Days <u>27</u> Hours <u>15</u> Min.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk. (Retired Farmer)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Worcester, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>				13. FATHER'S NAME <u>Wesley Carter</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Pusey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>Unk.</u>				17. INFORMANT <u>Mr. Lawrence J. Carter (Son) R.D.# 5 Sal. Md.</u> <u>Hospital Records -- Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 d.</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>2/23/61</u> , 19....., to <u>5/27/61</u> , 19....., that (I) (we) last saw the deceased alive on <u>5/27/61</u> , 19....., and that death occurred at <u>12AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>L. Maldve</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>May 27, 1961</u>											
22c. PHYSICIAN'S NAME (Type) <u>L. Maldve, M.D.</u>											
22d. ADDRESS <u>Deer's Head State Hospital--Salisbury, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
23b. DATE THEREOF <u>May 31, 1961</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>											
23d. LOCATION (City, town or county) (State) <u>Worcester Co. Maryland</u>											
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HORLOWAY &amp; COMPANY SALISBURY MARYLAND</u>											
25a. REC'D BY REGISTRAR <u>MAY 31 '61</u>											
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>											

M

1961, 73, 208

## CERTIFICATE OF DEATH

Reg. Dist. No. **06176**

6189

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>15 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>311 Broad Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jesse</b> Middle <b>Chapman</b> Last 4. DATE OF DEATH Month <b>5</b> Day <b>18</b> Year <b>1961</b>							
5. SEX <b>M</b>		6. COLOR OR RACE <b>AA</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Not positive</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Not known</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Not known</b>				14. MOTHER'S MAIDEN NAME <b>Not known</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>No</b>		INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0</b> DUE TO <b>Hepatic Cirrhosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Usual Causes</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Not known</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 15, 1961</b> to <b>May 18, 1961</b> that I last saw the deceased alive on <b>May 18, 1961</b> , and that death occurred at <b>12:20</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. Herbert Sembly</b> M.D.				ADDRESS (Street, city or town, state) <b>400 East Church St. Salisbury</b> DATE SIGNED <b>5/18/61</b>			
PHYSICIAN'S NAME (Type) <b>Herbert G. Sembly</b>				400 East Church St., Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>5-19-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ind. Anatomical Bd. Baltimore, Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thornton B. Jelley</b>				ADDRESS <b>Salisbury, Md</b>		24a. REC'D BY REGISTRAR <b>MAY 24 '61</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

City of \_\_\_\_\_

## CERTIFICATE OF DEATH

Reg. Dist. No. 06177

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>408 Stewarts Place</u>			
3. NAME OF DECEASED (Type or print) <u>George</u> First Middle Last				4. DATE OF DEATH <u>May</u> Month Day Year <u>8</u> <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1890</u>	
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Collins</u>				14. MOTHER'S MAIDEN NAME <u>Mary Corbin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Bessie Ellis 420 Stewart Place Salisbury Md</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>610X</u> DUE TO <u>Chemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bengin Prostatic Hypertrophy</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
18. INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u></u>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5-7</u> , 19 <u>61</u> , to <u>5-8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5-7</u> , 19 <u>61</u> , and that death occurred at <u>8:45</u> A.M., from the causes and on the date stated above.							
22. ADDRESS (Street, city or town, state) <u>Salisbury, Md</u>							
23. ACTUAL SIGNATURE <u>H. Gray Reeves, M.D.</u> M.D. DATE SIGNED <u>9 May 61</u>							
PHYSICIAN'S NAME (Type) <u>H. Gray Reeves, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
22b. DATE THEREOF <u>5/13/1961</u>							
22c. NAME OF CEMETERY OR CREMATORY <u>Glass Hill</u>							
22d. LOCATION (City, town, or county) (State) <u>Parsonsborg Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton O. Stewart</u> ADDRESS <u>Salisbury Md</u>							
24a. REC'D BY REGISTRAR <u>MAY 15 '61</u>							
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1

1110

CERTIFICATE OF DEATH

DECEASED

DECEASED

DECEASED

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Cause of death: [illegible]  
8. Place of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]  
11. Date of registration: [illegible]  
12. Place of registration: [illegible]

13. Name of informant: [illegible]  
14. Address of informant: [illegible]  
15. Signature of informant: [illegible]  
16. Date of information: [illegible]  
17. Place of information: [illegible]  
18. Signature of registrar: [illegible]  
19. Date of registration: [illegible]  
20. Place of registration: [illegible]

21. Name of registrar: [illegible]  
22. Address of registrar: [illegible]  
23. Signature of registrar: [illegible]  
24. Date of registration: [illegible]  
25. Place of registration: [illegible]

26. Name of registrar: [illegible]  
27. Address of registrar: [illegible]  
28. Signature of registrar: [illegible]  
29. Date of registration: [illegible]  
30. Place of registration: [illegible]

31. Name of registrar: [illegible]  
32. Address of registrar: [illegible]  
33. Signature of registrar: [illegible]  
34. Date of registration: [illegible]  
35. Place of registration: [illegible]

36. Name of registrar: [illegible]  
37. Address of registrar: [illegible]  
38. Signature of registrar: [illegible]  
39. Date of registration: [illegible]  
40. Place of registration: [illegible]

41. Name of registrar: [illegible]  
42. Address of registrar: [illegible]  
43. Signature of registrar: [illegible]  
44. Date of registration: [illegible]  
45. Place of registration: [illegible]

6191

## CERTIFICATE OF DEATH

Reg. Dist. No. 06178

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>1301 CHESTNUT</u>	
3. NAME OF DECEASED (Type or print) <u>Lee HobARTH Cox</u>		4. DATE OF DEATH <u>MAY 27</u> 19 <u>61</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-29-1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK COX</u>		14. MOTHER'S MAIDEN NAME <u>PRISCILLA TWIGG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>716-03-1653</u>	
17. INFORMANT <u>RAYMOND COX-LAUREL DEL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>? years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26-MAY</u> , 19 <u>61</u> , to <u>27 MAY</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>27 MAY</u> , 19 <u>61</u> , and that death occurred at <u>2:35</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph C. Fitzgerald</u>		ADDRESS (Street, city or town, state) <u>5/27/61</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-29-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>M-E</u>	22d. LOCATION (City, town, or county) (State) <u>DELMAR - DEL</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W-S-Morgan Co - Delmar Kent</u>		24a. REC'D BY REGISTRAR <u>MAY 31 '61</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

M

00112

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of birth: Jan 15 1866

5. Place of birth: New York City

6. Date of death: Dec 10 1911

7. Place of death: Home

8. Cause of death: Heart Disease

9. Signature of physician: Dr. J. Smith

10. Signature of registrar: John Doe

11. Date of registration: Dec 15 1911

12. Place of registration: New York City

6192

## CERTIFICATE OF DEATH

Reg. Dist. No. 06179

## 1. PLACE OF DEATH

a. COUNTY

WICOMICO

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

WICOMICO

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

SALISBURY

c. LENGTH OF STAY IN 1b

4 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X DELMAR

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

082 PENINSULA GENERAL HOSPITAL

d. STREET ADDRESS

R7D.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☐

## 3. NAME OF DECEASED (Type or print)

First

Middle

Last

EDWARD BLOXOM DAUGHERTY

## 4. DATE OF DEATH

Month

Day

Year

MAY

16

1961

## 5. SEX

MALE

## 6. COLOR OR RACE

WHITE

## 7. MARRIED

☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## 8. DATE OF BIRTH

3-7-1892

## 9. AGE (In years last birthday)

69 yrs.

## IF UNDER 1 YEAR

Months Days Hours Min.

## IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CONDUCTOR

10b. KIND OF BUSINESS OR INDUSTRY

RAILROAD

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME

GEORGE DAUGHERTY

## 14. MOTHER'S MAIDEN NAME

MARY EDNA BLOXOM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

NO

16. SOCIAL SECURITY NO.

716-01-6890

## INFORMANT

Address

DELLA DAUGHERTY - DELMAR MD.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

420.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Nat white at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from May 12, 1961, to May 16, 1961, that I last saw the deceased alive on May 15, 1961, and that death occurred at 3:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE

PHYSICIAN'S NAME (Type)

ADDRESS (Street, City or town, state)

DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

5-18-61

22c. NAME OF CEMETERY OR CREMATORY

Mt Olive

22d. LOCATION (City, town, or county)

Delmar

(State)

Del

23. FUNERAL DIRECTOR'S SIGNATURE

W-S. Mansel Co - Delmar, Del

ADDRESS

24a. REC'D BY REGISTRAR

DATE MAY 18 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Knead

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1933

CERTIFICATE OF DEATH

1933

WILLIAMS STATEMENT OF DEATH - PAGE 18  
1933

WILLIAMS STATEMENT OF DEATH - PAGE 18  
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WILLIAMS STATEMENT OF DEATH - PAGE 18  
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WILLIAMS STATEMENT OF DEATH - PAGE 18  
1933

6193

## CERTIFICATE OF DEATH

Reg. Dist. No. 06180

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILLARDS</u>	
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>CATHERINE</u> Last <u>DENNIS</u>		4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 15, 1903</u>
9. AGE (In years lost birthday) <u>57</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MITCHELL DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>ANNA HALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. G.C. Bounds</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Coronary Arterio sclerosis</u> DUE TO (c) <u>1 year</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 1960</u> to <u>May 9, 1961</u> , that I last saw the deceased alive on <u>May 8, 1961</u> , and that death occurred at <u>1:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill, M.D.</u>		ADDRESS (Street, city or town, state) <u>Pine Bluff Road 5/9/61</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/11/1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>DENNIS CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WILLARDS, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co. Salisbury, Md.</u>		24. REC'D BY REGISTRAR <u>May 12 '61</u>	
ADDRESS <u>Burge C. Hill</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1902

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams

W. C. Williams





## CERTIFICATE OF DEATH

Reg. Dist. No. 06182

6195

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Flower St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Herrickson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years lost birthday) yrs. <u>773.5</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Monfield Herrickson</u>		14. MOTHER'S MAIDEN NAME <u>Bobora Conway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Monfield Herrickson</u>		Address <u>Berlin</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Prematurity - 15 1/2 oz Birth Wt</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 29</u> , 19 <u>61</u> , to <u>May 29</u> , 19 <u>61</u> that I last saw the deceased alive on <u>May 29</u> , 19 <u>61</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>5/30/61</u>			
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D.		PHYSICIAN'S NAME (Type) _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 31 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Englewood Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u> ADDRESS _____		24a. REC'D BY REGISTRAR <u>JUN 5 '61</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon permits. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

6196

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06183

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shuttle Creek</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pleasant Care Nursing Home</u>				d. STREET ADDRESS <u>23X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>E.</u> Last <u>Dickerson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov 30 - 1890</u>		9. AGE (In years, last birthday) <u>70 1/2</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Cape Charles, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Dickerson</u>				14. MOTHER'S MAIDEN NAME <u>Jane Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Fannie Anthony, 306 Shy Hill Rd, Cape Charles, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10/60</u> to <u>5/31/61</u> , that (I) (we) last saw the deceased alive on <u>5/29/61</u> , and that death occurred at <u>5/31/61</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>J. C. Mitchell</u>				22b. DATE SIGNED <u>5/31/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Salisbury, Md</u>	
22d. ADDRESS				22e. REC'D BY REGISTRAR			
22f. REGISTRAR'S SIGNATURE				22g. DATE <u>JUN 5 '61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 2/61</u>				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Shuttle Creek, Md</u>				23e. (State) <u>md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne L. Smith</u>				24a. ADDRESS <u>Shuttle Creek, Md</u>			
24b. REC'D BY REGISTRAR				24c. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			
24d. DATE				24e. TIME			

CERTIFICATE OF DEATH

(M)

1914

State of Massachusetts  
County of Suffolk  
City of Boston  
I, the undersigned, Registrar of the City and County of Boston, do hereby certify that on the 1st day of May, 1914, at the City of Boston, in the County of Suffolk, State of Massachusetts, died William J. Sullivan, of the County of Suffolk, State of Massachusetts, aged 45 years, the result of heart disease, and that the death occurred at his residence, 123 North Street, Boston, Massachusetts.

(1)

Witness my hand and the seal of the City and County of Boston, this 1st day of May, 1914.  
Registrar of the City and County of Boston

## CERTIFICATE OF DEATH

Reg. Dist. No. 06184

6197

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>322 Naylor St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NETTIE</u> Middle <u>ELLEN</u> Last <u>DRYDEN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5, 1889</u>
9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>28</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Delmar, Delaware</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Thomas B. Calloway</u>		14. MOTHER'S MAIDEN NAME <u>Laura Beach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Mr. <u>J. Howard Dryden (Husband)</u> Address <u>322 Naylor St Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2.3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>N/A</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>	20f. (City or town) (County) (State) <u>N/A</u>
21. I certify that I attended the deceased from <u>4/11</u> , 19 <u>61</u> , to <u>5/3</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5/2/61</u> , 19 <u></u> , and that death occurred at <u>2 a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>S. Division St. Salisbury, Maryland</u> DATE SIGNED <u>May 3, 1961</u>			
ACTUAL SIGNATURE <u>Fred R. Grance</u> M.D.		PHYSICIAN'S NAME (Type) <u>Dr. Fred R. Grance</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 5, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>MAY 9 '61</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Grance</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1981 2 \*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

6198

06185

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>306 Buena Vista Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NATHAN</b> First <b>JAMES</b> Middle <b>FOSKEY</b> Last		4. DATE OF DEATH <b>MAY</b> Month <b>19th</b> Day <b>1961</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1890</b>
9. AGE (In years lost birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR <b>2</b> Months <b>3</b> Days	11. IF UNDER 24 HRS. <b>Hours</b> <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Mason</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Pittsville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Nathan Henry Foskey</b>		14. MOTHER'S MAIDEN NAME <b>Hennietta Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>Mr. Charlie H. Foskey (Son)</b> Address <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>451X Rupture - abdominal aortic aneurysm</b> DUE TO (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>5 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year <b>N/A 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <b>N/A</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>12/76</b> to <b>5/19</b> , 1961, that (I) (we) last saw the deceased alive on <b>5/19</b> , 1961, and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Earl M. Beardsley</b>		22b. DATE <b>May 22, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl M. Beardsley</b>		22d. ADDRESS <b>Maryland Ave. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 23, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>SALISBURY MARYLAND</b>	
25b. REGISTRAR'S SIGNATURE <b>DATE MAY 25 '61</b>		25c. REGISTRAR'S SIGNATURE <b>Carlton S. Kinn</b>	

CERTIFICATE OF DEATH

WISCONSIN

County of \_\_\_\_\_

City of \_\_\_\_\_

Deceased \_\_\_\_\_

Date of Death \_\_\_\_\_

Place of Death \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Signature of Coroner \_\_\_\_\_

CHIEF

WITNESSES

BY \_\_\_\_\_

Signature of Coroner

Printed by \_\_\_\_\_

Printed by \_\_\_\_\_

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>6799</div> <div>06186</div> </div>																	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> <b>Peninsula General Hospital</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland (Rural-Salisbury)</b> d. STREET ADDRESS <b>132 Clyde Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>William Thomas Foskey</b>			<b>4. DATE OF DEATH</b> Month <b>5</b> Day <b>22</b> Year <b>619</b>			<b>5. SEX</b> <b>M</b>			<b>6. COLOR OR RACE</b> <b>W</b>			<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
<b>8. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Line-man, Employee of E. S. P. S.</b>			<b>9. AGE</b> (In years last birthday) <b>31</b> yrs. IF UNDER 1 YEAR: Months <b>5</b> Days <b>22</b> IF UNDER 24 HRS.: Hours <b>619</b> Min.			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>E. S. P. S.</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>Salisbury, Maryland</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>					
<b>13. FATHER'S NAME</b> <b>William W. Foskey</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Nellie Frances Foskey</b>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Unk</b> (If yes give war or dates of service)						<b>16. SOCIAL SECURITY NO.</b> <b>220-12-1874</b>						<b>17. INFORMANT</b> <b>Mrs. Betty L. Foskey (Wife)</b> <b>132 Clyde Ave. (Fruitland) Salisbury, Maryland</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrocution</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>914.3</b> (c) <b>Sudden</b> DUE TO (e), stating the underlying cause last.																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.						<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Working on pole and touched wire with 12,000 Volts.</b>											
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>10:05 A.M. 5-22-61</b>						<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> <b>Quantico Road Salisbury Wicomico Md.</b>											
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)						<b>20f. (City or town)</b> <b>Salisbury</b> (County) (State)											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>.</b> and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>																	
<b>ACTUAL SIGNATURE</b> <b>Earl L. Royer, M.D.</b>						<b>DATE SIGNED</b> <b>5-23-61</b>											
<b>EXAMINER'S NAME</b> (Type) <b>407 Camden Ave. Salisbury, Md.</b>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>						<b>22b. DATE THEREOF</b> <b>May 25, 1961</b>											
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Wicomico Memorial Park</b>						<b>22d. LOCATION (City, town, or country)</b> <b>Salisbury, Maryland</b> (State)											
<b>23. FUNERAL DIRECTOR</b> <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>						<b>24a. REC'D BY REGISTRAR</b> <b>MAY 25 '61</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>											

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FOR STATE  
HEALTH DEPT.

6200  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06187

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>111 Jenkins Lane</b>			
3. NAME OF DECEASED (Type or print) <b>John Wesley Harmon</b>				4. DATE OF DEATH <b>5-8-61</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 31 1913</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>			
11. BIRTHPLACE (State or foreign country) <b>Sumner Co</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13. FATHER'S NAME <b>LEWIS HARMON</b>				14. MOTHER'S MAIDEN NAME <b>Lettie Harmon</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>012-12-3329</b>			
17. INFORMANT <b>Lettie Harmon</b>				18. ADDRESS <b>1721e BARKLEY</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Acute pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cerebral vascular accident</b> DUE TO (c) <b>Hypertensive cardio-vascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Sudden</b> <b>Years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L Royer</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>5-10-61</b>			
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF <b>5-11-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Flower Hill</b>		22d. LOCATION (City, town, or country) (State) <b>Eden Md.</b>	
23. FUNERAL DIRECTOR <b>Booker M. West</b>				24a. REC'D BY REGISTRAR <b>MAY 15 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
6201 06188											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.D. Golts (Sassafras)</b> d. STREET ADDRESS <b>14X-1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>John</b>			First <b>John</b> Middle <b>Hart</b> Last <b>Hart</b>			4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>7/20/1876</b>		9. AGE (In years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR Months <b>84</b> Days <b>26</b> Hours <b>1961</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Kent County Chesterville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>?</b>						14. MOTHER'S MAIDEN NAME <b>Eva Single</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or date of service)		17. INFORMANT <b>Deer's Head Hospital Records</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>5/10/1961</b> to <b>5/26/1961</b> , that (I) (we) last saw the deceased alive on <b>5/25/1961</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Lee L. Lawry</b>						22b. DATE SIGNED <b>5/26/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>LEE L. LAWRY, M.D.</b>						22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Md.</b>					
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <b>5-31-61</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Med. School</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR DATE <b>JUN 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>			

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## CERTIFICATE OF DEATH

Reg. Dist. No. 06189

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u> 46X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				d. STREET ADDRESS <u>GROVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM PURNELL HASTINGS</u>				4. DATE OF DEATH Month Day Year <u>MAY 2 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-20-1892</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BARBER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frederick Hastings</u>				14. MOTHER'S MAIDEN NAME <u>Mary Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>217-10-2100</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulated Incessional</u> <u>561.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hernia with Perforations</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>5-2</u> , 19 <u>61</u> , to <u>5-2</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5-2</u> , 19 <u>61</u> , and that death occurred at <u>10:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William D. Ellis, Jr.</u> M.D. <u>Salisbury, Md.</u>				DATE SIGNED <u>5-2-61</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-4-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons</u>		22d. LOCATION (City, town, or county) <u>Salisbury, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marshall Co - Salisbury, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>DATE MAY 4 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

100

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of birth  
7. Usual residence  
8. Cause of death  
9. Signature of physician  
10. Signature of registrar  
11. Signature of informant  
12. Name of informant  
13. Address of informant  
14. Date of completion  
15. Registrar's signature  
16. Registrar's name  
17. Registrar's address  
18. Registrar's title  
19. Registrar's phone  
20. Registrar's fax  
21. Registrar's email  
22. Registrar's website  
23. Registrar's social media  
24. Registrar's contact info  
25. Registrar's office hours  
26. Registrar's jurisdiction  
27. Registrar's authority  
28. Registrar's license  
29. Registrar's registration  
30. Registrar's certification  
31. Registrar's accreditation  
32. Registrar's membership  
33. Registrar's affiliation  
34. Registrar's association  
35. Registrar's organization  
36. Registrar's institution  
37. Registrar's employer  
38. Registrar's supervisor  
39. Registrar's manager  
40. Registrar's director  
41. Registrar's officer  
42. Registrar's representative  
43. Registrar's agent  
44. Registrar's delegate  
45. Registrar's proxy  
46. Registrar's substitute  
47. Registrar's alternate  
48. Registrar's backup  
49. Registrar's replacement  
50. Registrar's successor  
51. Registrar's heir  
52. Registrar's beneficiary  
53. Registrar's estate  
54. Registrar's inheritance  
55. Registrar's legacy  
56. Registrar's bequest  
57. Registrar's gift  
58. Registrar's donation  
59. Registrar's contribution  
60. Registrar's support  
61. Registrar's assistance  
62. Registrar's aid  
63. Registrar's help  
64. Registrar's service  
65. Registrar's work  
66. Registrar's job  
67. Registrar's career  
68. Registrar's profession  
69. Registrar's occupation  
70. Registrar's trade  
71. Registrar's business  
72. Registrar's industry  
73. Registrar's sector  
74. Registrar's field  
75. Registrar's area  
76. Registrar's domain  
77. Registrar's scope  
78. Registrar's range  
79. Registrar's extent  
80. Registrar's reach  
81. Registrar's impact  
82. Registrar's influence  
83. Registrar's effect  
84. Registrar's result  
85. Registrar's outcome  
86. Registrar's consequence  
87. Registrar's effect  
88. Registrar's impact  
89. Registrar's influence  
90. Registrar's effect  
91. Registrar's impact  
92. Registrar's influence  
93. Registrar's effect  
94. Registrar's impact  
95. Registrar's influence  
96. Registrar's effect  
97. Registrar's impact  
98. Registrar's influence  
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100. Registrar's impact

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 46190

6203

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
c. LENGTH OF STAY IN 1b <b>3 yrs.</b>				d. STREET ADDRESS <b>121 Holland Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>121 Holland Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>VERNON MARSHALL HAYES</b>				4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 12, 1907</b>	
9. AGE (In years lost birthday) <b>54</b> yrs.		10. KIND OF BUSINESS OR INDUSTRY <b>Life Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Manager</b>				13. FATHER'S NAME <b>William Franklin Hayes</b>			
14. MOTHER'S MAIDEN NAME <b>Elvira Knapp</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>W.W. II</b>			
16. SOCIAL SECURITY NO. <b>212-15-3133</b>				17. INFORMANT <b>Mrs. V. M. Hayes, 121 Holland Ave., Salisbury</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Heart Disease</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Atherosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Approx 2 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 13, 1959</b> to <b>May 5, 1961</b> , that I lost s/he the deceased alive on <b>May 5, 1961</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David J. Gilmore</b>		M.D. <b>Salisbury Md</b>		DATE SIGNED <b>May 8, 1961</b>			
PHYSICIAN'S NAME (Type) <b>David J. Gilmore</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/9/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunny Slope Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>West Point, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George C. Hill II</b> <b>Hill and Johnson Co. 705 E. Main St, Salisbury</b>				24a. REC'D BY REGISTRAR <b>MAY 10 1961</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Travis</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06191

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>		c. LENGTH OF STAY IN 1b <u>10 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Garland</u> Middle <u>Hayward</u> Last <u>Hayward</u>				4. DATE OF DEATH Month <u>5</u> Day <u>25</u> Year <u>19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/5/1947</u>	
9. AGE (In years last birthday) <u>14</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>William Shreeves</u>				14. MOTHER'S MAIDEN NAME <u>Hortense Hayward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Hortense Shreeves Delmar, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Basilar fracture skull &amp; brain stem injury</u> 12 hrs 813 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident collision with deceased who was riding a bicycle</u>					
20c. TIME OF INJURY Hour <u>9</u> a. m. <u>5-25</u> 19 <u>61</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 13</u>		20f. (City or town) (County) (State) <u>Wicomico. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Phyllis A. Insley</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Phyllis A. Insley</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/30/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ M.E.</u>		22d. LOCATION (City, town, or county) (State) <u>Punch And landing Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr, Princess Anne, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>	

MEDICAL CERTIFICATION

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## CERTIFICATE OF DEATH

Reg. Dist. No. **06192**

6205

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Accomack</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>Wattsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General</b>				d. STREET ADDRESS <b>83 X-3</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rae Virginia Hinmon</b>				4. DATE OF DEATH Month Day Year <b>May 16 1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-9-14</b>		9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Harmon</b>				14. MOTHER'S MAIDEN NAME <b>Ethel Bivins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213 18 4165</b>		INFORMANT Address <b>John S. Hinmon Wattsville, Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Renal Disease</b> <b>442X</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/16</b> , 19 <b>61</b> , to <b>5/16</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>5/15</b> , 19 <b>61</b> , and that death occurred at <b>4 A.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Salisbury, Maryland 5/16/61</b>							
ACTUAL SIGNATURE <b>David J. Gilmore</b>		M.D. <b>Salisbury, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>David J. Gilmore</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-21-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wattsville Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Wattsville, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Thomas Funeral Home</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 22 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
06193

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hosp</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. STREET ADDRESS <b>512 Washington St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SADIE</b> Middle <b>LEE</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>28th</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b> <b>DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>August 22, 1884</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Nanticoke, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Columbus Moore</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Webster</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stomach ulcer with hemorrhage</b> <b>540.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>5/28</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5/28/61</b> 19 <b>61</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Fred R. Gramse</b>		22b. DATE SIGNED <b>May 29 / 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Fred R. Gramse</b>		22d. ADDRESS <b>S. Division St Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 1, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Park</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>SALISBURY MARYLAND</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		DATE <b>MAY 31 '61</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vienna, Maryland</b>			
c. LENGTH OF STAY in 1b <b>6 days</b>		d. STREET ADDRESS <b>Rt. 1 Box 113</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Elmer T. Jones</b>		4. DATE OF DEATH <b>May 27 19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1910</b>		
9. AGE (In years last birthday) <b>50 yrs.</b>		IF UNDER 1 YEAR Months <b>27</b> Days <b>19</b> Hours <b>61</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Theodore Jones</b>		14. MOTHER'S MAIDEN NAME <b>Florence Molock</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-12-6051</b>			
17. INFORMANT <b>Arelia Jones, R.R. 1 Vienna, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent Cerebral thrombosis</b> DUE TO (b) <b>Cerebral A. S.</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Arteriosclerosis General</b> DUE TO (c) <b>Arteriosclerosis General</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>332x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>Years</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May 22, 1961</b> to <b>May 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 27, 1961</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>L. Maldve</b>		22b. DATE <b>May 28, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. Maldve, M.D.</b>		22d. ADDRESS <b>Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/31/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Aireys Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Dorchester County, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Kraus</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 31 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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Item 20 Film 288  
 6-15-61 ans

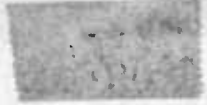
MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06195

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Mardela</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Powellville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.#(Maple Shad Nursing Home)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>BELLE</b> Last <b>KELLY</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>10th</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 22, 1880</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>18</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Powellville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles Bethards</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Crowley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mr. Henry P. Kelly (Husband)</b>		Address <b>Powellville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Femur</b> DUE TO <b>904.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombophlebitis</b> DUE TO <b>22 months</b> (c) <b>Pneumonia Labor</b> DUE TO <b>2 weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in home</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>Feb 25 19 61</b> p. m. <b>6</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	20f. (City or town) (County) (State) <b>Powellville Wic. Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>March 1, 1961</b> to <b>May 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 10 1961</b> , and that death occurred at <b>6:40 P. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>H. S. Kuhlman</b>		22b. DATE SIGNED <b>May 17 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. H. S. Kuhlman</b>		22d. ADDRESS <b>Sharptown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 13, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Powellville, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 16 '61</b>	

U.S. DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH



Name of deceased		Sex		Age	
John Doe		Male		45	
Date of death		Place of death		Cause of death	
August 22, 1988		Home		Heart disease	
Time of death		Manner of death		Occupation	
10:30 AM		Natural		Teacher	
Signature of physician		Signature of informant		Signature of registrar	
[Signature]		[Signature]		[Signature]	
Name of physician		Name of informant		Name of registrar	
Dr. J. K. Smith		Mrs. J. Doe		Mr. A. B. C.	
Address of physician		Address of informant		Address of registrar	
123 Main St.		456 Elm St.		789 Oak St.	
City		City		City	
State		State		State	
County		County		County	
Zip		Zip		Zip	
10000		10000		10000	

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06196

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Route # 2</b>		e. STREET ADDRESS <b>Route # 2</b>	
3. NAME OF DECEASED (Type or print) <b>Key Frances King</b>		4. DATE OF DEATH <b>5-7-61</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-31-60</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
10a. FATHER'S NAME <b>Oliver King</b>		11. BIRTH PLACE (State or foreign country) <b>Maryland</b>	
10b. MOTHER'S MAIDEN NAME <b>Sarah Wessels</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>D</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Asphyxia</b> 92410 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Sudden</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Infant sleeping in double bed with parents found dead in A.M.</b>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>6 A.M. 5-7-61</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20e. (City or town) <b>Eden</b>		20f. (County) <b>Wicomico</b>	
20g. (State) <b>Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		DATE SIGNED <b>5-11-61</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE OF BURIAL, CREMATION, OR REMOVAL <b>5-8-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Friendship Cem</b>		22d. LOCATION (City, town, or country) <b>Allen, Md.</b>	
23. FUNERAL DIRECTOR <b>Thornton B. Solley, Salisbury, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 25 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. King</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06197

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hosp</b>		d. STREET ADDRESS <b>R.D.# 3(Delmar Rd)</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>BABY BOY LAMB</b>		4. DATE OF DEATH Month <b>May</b> Day <b>4th</b> Year <b>1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2:28A.M. May 3, 1961</b>	
9. AGE (In years last birthday) <b>0</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
11. IF UNDER 24 HRS. Hours <b>23</b> Minutes <b>42</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unk</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Layfield</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Helen C. Layfield</b>		Address <b>(R.D.#3) Delmar Rd Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>773.5 atelectasis</b> DUE TO (b) <b>Prerenal azotemia</b> DUE TO (c) <b>Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>N/A 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <b>N/A</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2:18A.M.</b> 19 <b>May 5</b> , that (I) (we) last saw the deceased alive on <b>May 5</b> 19 <b>May 5</b> , and that death occurred at <b>May 5</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. William B. Smith</b>		22b. DATE SIGNED <b>May 5 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. William B. Smith</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 6, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
25a. REC'D BY REGISTRAR <b>MAY 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

06198

6211

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>1 WEEK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY</u>		2342-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>605 SECOND ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>STANLEY P. LAMBDEN</u>				4. DATE OF DEATH Month Day Year <u>MAY 25 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 16, 1889</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT JAMES LAMBDEN</u>				14. MOTHER'S MAIDEN NAME <u>ELLA JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>W.W.#1 213-18-4973</u>		INFORMANT Address <u>MRS ZELLA LAMBDEN, 605 SECOND ST. POCOMOKE CITY, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous Subarachnoid Hemorrhage</u> 330X DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-19</u> , 19 <u>61</u> , to <u>5-25</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5-25</u> , 19 <u>61</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter R. Ellis Jr.</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>5-25-61</u>	
PHYSICIAN'S NAME (Type) <u>WILBUR R. ELLIS JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-27-61</u>		22c. NAME OF CEMETERY <u>BETHANY METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Watson</u>				ADDRESS <u>POCOMOKE CITY, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 29 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. F...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

Name of Deceased John M. Johnson  
 Sex Male  
 Date of Birth Sept. 10, 1859  
 Place of Birth St. Louis, Mo.  
 Residence at Date of Death St. Louis, Mo.  
 Usual Occupation Teacher  
 Cause of Death Heart Failure  
 Date of Death Sept. 10, 1911  
 Place of Death St. Louis, Mo.  
 Name of Physician Dr. J. M. Johnson  
 Name of Undertaker John M. Johnson  
 Name of Burial Place St. Louis, Mo.  
 Name of Minister of the Gospel St. Louis, Mo.  
 Name of Coroner St. Louis, Mo.  
 Name of Registrar St. Louis, Mo.

I, John M. Johnson, being a duly qualified physician, do hereby certify that the above is a true and correct statement of the facts in the case of the above named deceased, and that he died on the 10th day of September, 1911, at the place of death above stated, and that the cause of death was Heart Failure.  
 Witness my hand and seal this 10th day of September, 1911.  
 Dr. J. M. Johnson  
 Physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6212

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06199

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt 1 Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Koroller Dr. Rt 1 Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>1</u>			
e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELMER MURRAY LEWIS</u>				4. DATE OF DEATH Month Day Year <u>MAY 12 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 10, 1882</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rt Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen Merchant Parkley Va.</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>William H. Lewis (dec)</u>				14. MOTHER'S MAIDEN NAME <u>Aritha Barnes (dec)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mr. E. Lewis</u>				Address <u>Parkley, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetic nephrosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic gangrene, toes, generalized arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 17 1961</u> to <u>MAY 12 1961</u> , that (I) (not) last saw the deceased alive on <u>MAY 10 1961</u> , and that death occurred at <u>9:50 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert T. Adkins</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 12, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert T. Adkins</u>				22d. ADDRESS <u>FRUITLAND, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5/14/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Liberty</u>		23d. LOCATION (City, town, or county) (State) <u>Parkley, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Richard Johnson, Parkley, Va.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thompson</u>	

1913

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UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

WISCONSIN

County of \_\_\_\_\_  
City of \_\_\_\_\_

DECEASED

WIFE OF

\_\_\_\_\_

NAME OF DECEASED \_\_\_\_\_  
AGE \_\_\_\_\_  
SEX \_\_\_\_\_

DATE OF DEATH \_\_\_\_\_  
PLACE OF DEATH \_\_\_\_\_  
CAUSE OF DEATH \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_  
MANNER OF DEATH \_\_\_\_\_  
SIGNATURE OF PHYSICIAN \_\_\_\_\_

TESTIFYING PHYSICIAN \_\_\_\_\_

DATE OF DEATH \_\_\_\_\_  
TIME OF DEATH \_\_\_\_\_

DECEASED

ROBERT T. HOBBS

DECEASED

TESTIFYING PHYSICIAN \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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6213  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
66200

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY in 1b <b>42 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>DEER'S HEAD STATE HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland</b> d. STREET ADDRESS <b>Rt. 2, Stone Boundary Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>Julia Ann McKinley</b>				<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>29</b> Year <b>19 61</b>											
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>1883</b>		<b>9. AGE</b> (In years last birthday) <b>78</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>--</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Unknown</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>-</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>-</b>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>--</b>		<b>17. INFORMANT</b> <b>Deer's Head Hospital Records, Salisbury, Md.</b>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease, Decompensated</b> DUE TO (b) <b>Arteriosclerosis, general and cerebral</b> DUE TO (c) <b>422.01</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 weeks</b> <b>Years</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>(1) Lues; (2) Decubitus ulcers, severe</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from April 17, 1961 to May 29, 1961, that (I) (we) last saw the deceased alive on May 29, 1961, and that death occurred at 10:27AM, from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <b>V. Juerman</b>				<b>22b. DATE SIGNED</b> <b>5/31/61</b>		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>									
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>V. Juerman, M. D.</b>				<b>22d. ADDRESS</b> <b>Deer's Head State Hospital, Salisbury, Md.</b>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>6/1/61</b>				<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Wolfe-Med. Schuy</b>		<b>23d. LOCATION (City, town or county)</b> <b>Salisbury, Md.</b>		<b>(State)</b>					
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b>				<b>ADDRESS</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUN 5 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hance</b>							

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officer

Yours  
Sincerely

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 13 & 14 Film 0288 5/29/61 mh

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>2 Wks.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>ARNOLD</b> Last <b>MILES</b>		4. DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1879</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alfred S. Miles</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Byrd</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>19-22-1961</b>	
17. INFORMANT <b>Mrs. Harry R. Hearn, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Semility</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-2-1955</b> to <b>5-22-1961</b> , that (I) (we) last saw the deceased alive on <b>5-22-1961</b> , and that death occurred at <b>2:50 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Andrew C. Mitchell</b>		22b. DATE <b>5-23-1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Andrew C. Mitchell</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-25-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Norman F. Baker</b>		25. REC'D BY REGISTRAR <b>MAY 25 '61</b>	
ADDRESS <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles P. Hearn</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No. 6215

6215

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>19X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>P.O. Box</u>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>moore</u> Middle Last				4. DATE OF DEATH <u>May</u> 5- 19 <u>61</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 15 1886</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME, <u>Sidney Moore</u>				14. MOTHER'S MAIDEN NAME <u>Caroline ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		INFORMANT <u>Jennie Moore - Manokin, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia acute &amp; Cerebral Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/17/61</u> , 19 <u>61</u> , to <u>May 5</u> , 19 <u>61</u> that I last saw the deceased alive on <u>May 4</u> , 19 <u>61</u> , and that death occurred at <u>8:45</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u>		M.D. <u>Salisbury, Md.</u>		ADDRESS (Street, city or town, state) <u>May 5, 1961</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-8-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lindley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>MAY 9 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 06203

6216

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blades</u> 46X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>		d. STREET ADDRESS <u>16 West Third Street</u>	
3. NAME OF DECEASED (Type or print) First <u>IVA</u> Middle <u>FRANCES</u> Last <u>O'Neal</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 24, 1893</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elijah Bradley</u>		14. MOTHER'S MAIDEN NAME <u>Euphemia Phillips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-9208</u>	
17. INFORMANT <u>Mrs. Arnette F. Baker</u>		Address <u>19 E. Fourth St. Blades, Delaware</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 60000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Pyelonephritis</u> DUE TO (c) <u>Start 2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/20</u> , 19 <u>60</u> , to <u>May 1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>May 1</u> , 19 <u>61</u> , and that death occurred at <u>9:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u>		ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>5/1/61</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 4, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Blades Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Blades, Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ryner M. Watson</u>		ADDRESS <u>Seaford, Delaware</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

116



County of Franklin State of Idaho  
I, John A. Smith, Registrar of the County of Franklin, State of Idaho, do hereby certify that on the 15th day of July, 1924, at Boise, Idaho, died John A. Smith, of the County of Franklin, State of Idaho, who was born on the 10th day of January, 1875, at Boise, Idaho, and was a resident of the County of Franklin, State of Idaho, at the time of his death. He was a single man, of the white race, and his occupation was that of a carpenter. He died of heart disease, which was the result of hypertension. The attending physician was Dr. J. H. Jones, of Boise, Idaho. The body was buried in the Boise City Cemetery, in the Boise City, Idaho, on the 16th day of July, 1924.  
Witness my hand and the seal of said County, at Boise, Idaho, this 15th day of July, 1924.  
John A. Smith, Registrar

*[Faint, illegible text and signatures at the bottom of the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR AIS (4)  
15M 9/59

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6217  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
46204

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>		c. LENGTH OF STAY IN 1b <b>25 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>JAMES</b> First <b>FRANKLIN</b> Middle <b>PARKER</b> Last		4. DATE OF DEATH Month <b>5</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>71</b> Days <b>18</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer Own Farm</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jonathan Parker</b>		14. MOTHER'S MAIDEN NAME <b>Annie Bailey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mrs. Nellie F. Parker, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> (did immediately) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension, arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> 19 to <b>5-18-61</b> 19, that (I) (we) last saw the deceased alive on <b>5-16</b> 19 <b>61</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank Lewis</b>		22b. DATE SIGNED <b>5-19-1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Frank R. Lewis</b>		22d. ADDRESS <b>Willards, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-21-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Pittsville, Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Pittsville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 22 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>		25c. DATE <b>MAY 22 '61</b>	

*Norman F. Baker*

CERTIFICATE OF DEATH

1933

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1888		New York City	
Cause of Death		Manner of Death		Occupation		Residence		Signature of Physician	
Heart Disease		Natural		Teacher		123 Main St		Dr. Smith	
Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Coroner	
Jan 15, 1933		10:30 AM		Home		J. Doe		W. Doe	
Burial Place		Burial Date		Burial Time		Burial Place		Signature of Minister	
Cemetery		Jan 18, 1933		11:00 AM		Cemetery		Rev. Doe	

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FOR STATE  
HEALTH DEPT.

(M)

(I)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.

BP

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6218

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06205

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>		d. STREET ADDRESS <b>Box 61</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D.O.A. Peninsula General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Richard Thomas Parsons</b>				4. DATE OF DEATH Month <b>5</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1941</b>		9. AGE (In years last birthday) <b>19</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Lester R. Parsons</b>				14. MOTHER'S MAIDEN NAME <b>Della Truitt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Father: Mr. Lester Parsons</b>		Address <b>Pittsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Traumatic pneumothorax- left</b> <b>816X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Puncture wound of chest.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Driver of car involved in two car collision.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
20a. EXTENSIONAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car involved in two car collision.</b>					
20c. TIME OF INJURY Month, Day, Year <b>6:30 P.M. 5-2-61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Salisbury Wicomico Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>5-4-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-5-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Perdue Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Powellville, Md.</b>	
23. FUNERAL DIRECTOR <b>Holloway and Co. Salisbury, Md.</b>				24a. REC'D BY REGISTRAR <b>MAY 9 '61</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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McLanahan and Co., Salisbury, Md.

Salisbury, Md.

Salisbury, Md.

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Salisbury, Md.

Driver of car involved in two car collision.

Thompson House of Sleep.

Thompson House of Sleep.

Salisbury, Md.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 06206

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R710. 46X-1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANKLIN MCKINLEY PUSEY</u>				4. DATE OF DEATH Month Day Year <u>May 19 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-1901</u>		9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WOOD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE PUSEY</u>				14. MOTHER'S MAIDEN NAME <u>ANNE QUILLEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-12-5380</u>		INFORMANT Address <u>DELENA PUSEY-DELMAR DEL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4204</u> DUE TO <u>Coronary Artery Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>May 18 1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 16</u> , 19 <u>61</u> , to <u>May 19</u> , 19 <u>61</u> , that I lost s/he the deceased alive on <u>May 18</u> , 19 <u>61</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>May 19, 1961</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-21-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>1st Pleasant</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W-S. Marvel Co, Delmar Del</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

COPIES OF DEATH CERTIFICATE

2018

CERTIFICATE OF DEATH

George Jones  
Died at his residence  
1234 Main Street  
City, State, U.S.A.  
on the 15th day of  
January, 1901  
at the age of 65 years  
Cause of death  
Heart disease  
Signed and sealed  
this 15th day of  
January, 1901  
at the City of New York  
in the State of New York  
I, J. D. Smith, Registrar  
of Deaths, do hereby  
certify that the  
above is a true and  
correct copy of the  
original certificate  
of death filed in  
my office.

X

Witness my hand and seal  
this 15th day of January, 1901  
at the City of New York  
in the State of New York

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

6220

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06207

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Since 4/24/61</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>		d. STREET ADDRESS <b>Hobbs Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pine Bluff State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Stanley</b> Middle <b>-</b> Last <b>Reed</b>		4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/25/1891</b>
9. AGE (In years last birthday) <b>69</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clem Reed</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Buckmaster</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Records of Pine Bluff State Hospital</b>	
17. INFORMANT <b>Records of Pine Bluff State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Pulmonary Tuberculosis</b> IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Tuberculosis</b> DUE TO (c) <b>Pulmonary Tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 24, 1961</b> to <b>May 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 17, 1961</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>E. P. Ritchings</b>		22b. DATE <b>5/18/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. P. Ritchings</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 20, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Denton</b>		23d. LOCATION (City, town, or county) (State) <b>Denton, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Moore</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 22 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>William S. Kneass</b>			

CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 File # 6287 5/22/61 mh

## CERTIFICATE OF DEATH

Reg. Dist. No.

06208

6221

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert L. RICKETTS</u> First Middle Last				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 4 1878</u> yrs.	
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Oriskany Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ricketts</u>				14. MOTHER'S MAIDEN NAME <u>Esther Bennett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>Willie Bennett, Oriskany Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>540.8</u> IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) <u>Perforated peptic ulcer</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASCVD</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Today</u> <u>7 days?</u> <u>7 days?</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9 May</u> , 19 <u>61</u> , to <u>13 May</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>13 May</u> , 19 <u>61</u> , and that death occurred at <u>1:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Peninsula General Hospital</u> DATE SIGNED <u>5/13/61</u> ACTUAL SIGNATURE <u>Alfred W. Grigoleit</u> M.D. PHYSICIAN'S NAME (Type) <u>ALFRED W. GRIGOLEIT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-15-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oriskany Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oriskany Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin B. Mullan</u>				24. REC'D BY REGISTRAR <u>May 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

James

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## CERTIFICATE OF DEATH

Reg. Dist. No.

06200

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>12 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Edgar</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/12/1881</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Charles W. Robinson</u>				14. MOTHER'S MAIDEN NAME <u>  </u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>Charles Robinson, Mardela, Md.</u>				Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 581.0 DUE TO <u>Pulmonary Infections, Multiple</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Cirrhosis of liver with ascites.</u> (c) <u>Malnutrition.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 week</u> <u>years</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>61</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>4/26</u> , 19 <u>61</u> , to <u>May 8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>May 7</u> , 19 <u>61</u> , and that death occurred at <u>11:12 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u>				ADDRESS (Street, city or town, state) <u>PINEBLUFF ROAD, Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>				DATE SIGNED <u>5/8/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				22b. DATE THEREOF <u>5/10/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Turners Cem.</u>	
22d. LOCATION (City, town, or county) <u>Nantuxike, Md.</u>				22e. (State) <u>  </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Christyessut, Bivolve, Md.</u>				ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR <u>MAY 12 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				DATE <u>  </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

6226

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06210

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wicomico River</b>			d. STREET ADDRESS <b>685 Fitzwater St.</b>		
3. NAME OF DECEASED (Type or print) <b>Brock Lamont Satchell</b>			4. DATE OF DEATH <b>5-8-61</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1948</b>		9. AGE (In years last birthday) <b>12</b> yrs. <b>5-8-61</b> <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Rogest Myers</b>			14. MOTHER'S MAIDEN NAME <b>Mrs. Mary Satchell</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Mrs. Mary Jones</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>Fell from pier pilings while fishing.</b>			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year <b>6:30 P.M. 5-8-61</b>			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Wicomico River Salisbury Wicomico Md.</b>			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Earl L. Royer</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>May 10, 1961</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>green acres</b>			22d. LOCATION (City, town, or country) <b>Salisbury Md.</b>		
23. FUNERAL DIRECTOR <b>Clifton F. Stewart</b>			24a. REC'D BY REGISTRAR <b>DATE MAY 22 '61</b>		
			24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		

MEDICAL CERTIFICATION

FOR SALE  
LARGE LOT

W. H. HARRIS

221 South

Wisconsin River

Smoke House

CHINA

Time

Nowing

Left from place 11:15 a.m. 11/11/11

6:30 p.m. 11/11/11 - 11/11/11 - 11/11/11

*[Handwritten signature]*

1000 1000 1000

*[Faint handwritten text at bottom]*

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6224 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 0621											
1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b> c. LENGTH OF STAY IN 1b <b>22 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>209 W. COLLEGE AVE.</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b> d. STREET ADDRESS <b>209 W. COLLEGE AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>BERNICE BUNDICK SHOCKLEY</b>						4. DATE OF DEATH <b>5 30 19 61</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 24, 1894</b>		9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>				11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN BUNDICK</b>						14. MOTHER'S MAIDEN NAME <b>EMMA SHRIEVES</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>						16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>E.E. SHOCKLEY</b> Address <b>SAME</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Thrombosis</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>5-31-61</b> Address (Street, city, town, or county)											
ACTUAL SIGNATURE <b>Philip A. Insley</b> EXAMINER'S NAME (Type) <b>Philip A. Insley</b>				M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE HEREOF <b>6-2-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wic. MEM. PARK</b>		22d. LOCATION (City, town, or country) (State) <b>SALISBURY, MARYLAND</b>			
23. FUNERAL DIRECTOR <b>HILL &amp; JOHNSON CO., SALISBURY, AMRYLAND</b> ADDRESS <b>GEORGE C. HILL, II</b>						24a. REC'D BY REGISTRAR <b>JUN 2 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>			

FOR STATE  
HEALTH DEPT.

(M)

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THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON HAS BEEN EXAMINED BY THE PHYSICIAN IN CHARGE OF THE STATE HOSPITAL AND FOUND TO BE A PATIENT OF THE HOSPITAL.

## CERTIFICATE OF DEATH

Reg. Dist. No. **06212**

6225

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>All his life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>608 West Isabella St</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Stanley</b> Middle <b>E.</b> Last <b>Shockley</b>				4. DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1918</b>		9. AGE (In years last birthday) <b>42</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>22</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hearl Shockley</b>				14. MOTHER'S MAIDEN NAME <b>Essie Hayman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW #2 217-10-2452</b>		INFORMANT <b>Mrs. Essie Mason, Salisbury, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Left Ventricular Hypertrophy</b> DUE TO <b>definite</b> (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 May, 1961</b> to <b>22 May, 1961</b> , that I last saw the deceased alive on <b>22 May, 1961</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. Purnell</b>				DATE SIGNED <b>62 West Main Salisbury Md 22 May 61</b>			
PHYSICIAN'S NAME (Type) <b>E. A. Purnell, M.D. 657 West Main St., Salisbury, Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/28/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Fruitland, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thornton B. Jolley, Salisbury, Md</b>				24a. REC'D BY REGISTRAR <b>MAY 29 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06213

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>Route # 3</b>	
3. NAME OF DECEASED (Type or print) <b>Derick A Spence</b>		4. DATE OF DEATH <b>5-22-61</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-24-58</b>
9. AGE (In years last birthday) <b>2</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>22</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Robert Spence</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Bridell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Father: Robert Spence, Berlin, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Second and third degree burns 80% body surface.</b> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Child trapped in burning house.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Child trapped in burning house.</b>	
20c. TIME OF INJURY Month, Day, Year <b>6 P.M. 5-21-61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> X <b>House</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Berlin</b>		20f. (City or town) (County) (State) <b>Worcester Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> X Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		DATE SIGNED <b>5-23-61</b>	
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/23/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Berlin, Maryland</b>	
23. FUNERAL DIRECTOR <b>Thronten B. Jolley, Salisbury, Md</b>		24a. REC'D BY REGISTRAR <b>MAY 29 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100000

Alcoholic

Salisbury

Peninsula General Hospital

Route 3

Spence

Deaton

10-22-51

11-2-58

Child

Marland

Female Child

Robert Spence

Robert; Robert Spence, Berlin, Md.

Second and third degree burns 50% body surface.

Child trapped in burning house.

6 P.M. 10-21-51 Berlin, Worcester, Md.

10-21-51  
Capt. L. Roper, U.S. Army  
107 Cannon Ave., Salisbury, Md.

5/23/51

Thompson B. Jolley, Salisbury, Md.

## CERTIFICATE OF DEATH

Reg. Dist. No. 06214

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>3 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Amelia Baines Taylor</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1908</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Exmore, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ennis Baines</u>		14. MOTHER'S MAIDEN NAME <u>Florence Brickhouse</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-34-7641</u>	
17. INFORMANT <u>Frank Taylor</u>		18. ADDRESS <u>R.D.#2 Bunting Rd Pocomoke</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advanced Pulmonary Tuberculosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-10-</u> 19 <u>61</u> , to <u>5-13-</u> 19 <u>61</u> , that I last saw the deceased alive on <u>5-13-</u> 19 <u>61</u> , and that death occurred at <u>5:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Eddis, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>5-13-61</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-17-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Bapt. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Wardtown, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>		24a. REC'D BY REGISTRAR <u>MAY 16 '61</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1923

Maryland Worcester

3 Days

3 Days

RFD #2 Farmington Rd

Annalia

Baines

May 1, 1908

Domestic

Housewife

Domestic

U.S.A.

Flourace Brick house

Ennis Baines

No

218-34-1041

218-34-1041

218-34-1041

218-34-1041

218-34-1041

218-34-1041

218-34-1041

218-34-1041

218-34-1041

218-34-1041

218-34-1041

Funeral 2-11-61

Funeral 2-11-61

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6228  
6225  
Item 6 Film G287 5/24/61 iwk  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne, Maryland</b> d. STREET ADDRESS <b>23 Beechwood</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b> c. LENGTH OF STAY IN 1b <b>1 month</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>		f. STREET ADDRESS <b>19x-2</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Cora Hadey Thomas</b>		4. DATE OF DEATH Month Day Year <b>May 13 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1870</b>
9. AGE (In years last birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Simcox</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Dunn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Bessie Carey Princess Anne, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis (recurrent)</b> <b>332X</b> DUE TO <b>Arteriosclerosis, general.</b> Conditions, if any, which gave rise to immediate cause (b) } DUE TO (e), stating the underlying cause last. (c) }			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 13, 1961</b> , to <b>May 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 13, 1961</b> , and that death occurred at <b>6 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>L. Maldve</b> M.D.		22b. DATE <b>May 14, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Maldve, M.D.</b>		22d. ADDRESS <b>Deer's Head Hospital Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5-17-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Manokin Presbyterian Cem. Pr. Anne, Md.</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Levin R. Wilson</b>		25a. REC'D BY REGISTRAR <b>MAY 22 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>			

00713



July 22, 1950

U.S.A.

Ohio

Blanchard

Joseph Simon

The Hanna Cany. Express, Inc.

1

Blanchard

July 22, 1950

U.S.A.

Blanchard

Blanchard

Blanchard

Blanchard

## CERTIFICATE OF DEATH

Reg. Dist. No.

06216

6229

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Lisa</u> Middle <u>Louise</u> Last <u>Trader</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1961</u>	9. AGE (In years last birthday) <u>ys.</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ralph Trader</u>				14. MOTHER'S MAIDEN NAME <u>Letha White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Prematurity</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>5/5, 1961</u> , to <u>5/5, 1961</u> , that I last saw the deceased alive on <u>5/5/61</u> , 19____, and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm B Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Med. Center Salisbury</u>		DATE SIGNED <u>5/5/61</u>	
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 6, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John</u>	22d. LOCATION (City, town, or county) (State) <u>Deal Island Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Hannon</u> ADDRESS <u>Princess Anne Md.</u>				24a. REC'D BY REGISTRAR <u>DATE MAY 8 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>		

TO HOSPITAL—ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082332XVC

11/11/11

CERTIFICATE OF DEATH

1030

(M)

State of New York  
County of Westchester

That I, the undersigned, a duly qualified and licensed physician, do hereby certify that

the within and foregoing is a true and correct copy of the original as the same appears in my records

Witness my hand and seal this 11th day of November, 1911

at New York

My commission expires the 11th day of November, 1912

Notary Public in and for the State of New York

My commission expires the 11th day of November, 1912

Notary Public in and for the State of New York

My commission expires the 11th day of November, 1912

Notary Public in and for the State of New York

My commission expires the 11th day of November, 1912

6239

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06217

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico MARYLAND</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>						c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>516 Tangier St</b>						d. STREET ADDRESS <b>516 Tangier St.</b>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>Sherionie Tucker</b> First Middle Last						<b>4. DATE OF DEATH</b> Month Day Year <b>5-4-61 19</b>											
<b>5. SEX</b> <b>F</b>		<b>6. COLOR OR RACE</b> <b>C</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>12/31/60 Jan. 4, 1961</b>		<b>9. AGE</b> (If years last birthday) yrs. <b>54</b>		<b>IF UNDER 1 YEAR</b> Months Days <b>54</b>		<b>IF UNDER 24 HRS.</b> Hours Min. <b>54</b>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>					
<b>13. FATHER'S NAME</b> <b>William Showell</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Gloria Tucker</b>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)						<b>16. SOCIAL SECURITY NO.</b>						<b>17. INFORMANT</b> <b>Gloria Tucker, Salisbury, Md</b> Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Hours</b>					
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Interstitial pneumonitis</b> <b>525X DUE TO</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } <b>(b)</b> <b>DUE TO</b> <b>(c)</b>																	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury In Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town) (County) (State)</b>					
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
<b>ACTUAL SIGNATURE</b> <i>[Signature]</i> <b>EXAMINER'S NAME (Type)</b> <b>Earl L. Jolley</b>																<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <b>5-4-61</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>5/6/61</b>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Green Acre Cem.</b>				<b>22d. LOCATION (City, town, or country) (State)</b> <b>Salisbury, Md</b>					
<b>23. FUNERAL DIRECTOR</b> <b>Thornton B. Jolley, Salisbury, Md</b> ADDRESS								<b>24a. REC'D BY REGISTRAR</b> <b>DATE MAY 15 '61</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>					

VS. A15ME  
5M 9/60

2082-162 x V4

THE STATE  
OF NEW YORK

M

1

Ernest A. Jolley, Plaintiff,  
vs.  
The State of New York, Defendant.

John A. Jolley, Attorney for Plaintiff,  
New York City, New York.

George A. Jolley, Attorney for Defendant,  
New York City, New York.

That the Plaintiff is a resident of the State of New York.

That the Defendant is the State of New York.

That the Plaintiff is entitled to the relief requested.

That the Plaintiff is entitled to the relief requested.

That the Plaintiff is entitled to the relief requested.

That the Plaintiff is entitled to the relief requested.

That the Plaintiff is entitled to the relief requested.

That the Plaintiff is entitled to the relief requested.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
6231											
06218											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>			c. LENGTH OF STAY IN 1b <b>60 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5 East Street</b>					d. STREET ADDRESS <b>5 East Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ADELIA</b> Middle <b>ELLA</b> Last <b>VINCENT</b>					4. DATE OF DEATH Month <b>May</b> Day <b>28th</b> Year <b>1961</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 27, 1873</b>		9. AGE (In years last birthday) <b>87</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Vincent Waller, Delmar, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarct</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary occlusion</b> DUE TO (c) <b>coronary arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b> <b>4 hrs</b> <b>?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>1946</b> to <b>May 29, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 28, 1961</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>L.V. Sohler</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr. L.V. Sohler</b>					22d. ADDRESS <b>Delmar, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>			23d. LOCATION (City, town, or county) (State) <b>Delmar, Del.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.S. Marvel Co - Delmar, Del.</b>					25a. REC'D BY REGISTRAR DATE <b>MAY 31 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>				



5531

CERTIFICATE OF DEATH

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS

FILED IN

11/11/1911

**1**  
**FOR STATE**  
**HEALTH DEPT.**

**MARYLAND STATE DEPARTMENT OF HEALTH**

**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

6232

06219

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Dagsboro Road</b>		e. STREET ADDRESS <b>Dagsboro Road</b>	
3. NAME OF DECEASED (Type or print) <b>Olive Beulah Ward</b>		4. DATE OF DEATH Month <b>5</b> Day <b>2</b> Year <b>61</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-11-1897</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b>	
11. IF UNDER 24 HRS. Hours <b>11</b> Min. <b>00</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>	
13. FATHER'S NAME <b>Thomas Donoho</b>		14. MOTHER'S MAIDEN NAME <b>Mardela, Md.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>1-11-1897</b>	
17. INFORMANT <b>Mary Budd</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compound fracture of skull: fractured cervical spine</b> DUE TO (b) <b>816X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car involved in two car collision.</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:30 A.M. 5-2-61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Salisbury Wicomico Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury Md.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-4-61</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Salisbury Md.</b>	
23. FUNERAL DIRECTOR <b>Holloway and Co. Salisbury, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 9 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thane</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION  
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Danahoe and

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1-1-1937

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1-1-1937

Aluminum

Aluminum

Thomas Danahoe

Thomas Danahoe  
Salisbury, Md.

No

Thomas Danahoe  
Salisbury, Md.

Driver of car involved in the collision.

Salisbury, Md.

1-1-1937

Salisbury, Md.

Salisbury, Md.

Salisbury, Md.

Salisbury, Md.

Salisbury, Md.



CERTIFICATE OF DEATH

1903

County of Wisconsin

State of Wisconsin

City of Milwaukee

County of Milwaukee

I, the undersigned, a duly qualified physician, do hereby certify that

the within and foregoing is a true and correct copy of the

original as the same appears in the records of the

City of Milwaukee, Wisconsin, and that the same is a true and correct

copy of the original as the same appears in the records of the

City of Milwaukee, Wisconsin, and that the same is a true and correct

copy of the original as the same appears in the records of the

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City of Milwaukee, Wisconsin, and that the same is a true and correct

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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6234

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06221

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>				d. STREET ADDRESS <b>In Village</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>VIRGIL PRETTYMAN WILKINS</b>				4. DATE OF DEATH <b>MAY 11th 19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 8, 1877</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Wicomico Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Elisha P. Wilkins</b>				14. MOTHER'S MAIDEN NAME <b>Sarah E. Dickerson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Annie H. Wilkins (Wife)</b> Address <b>Parsonsbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>included</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/C</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/C</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/C</b>		20f. (City or town) (County) (State) <b>N/C</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4-11</b> to <b>5-11</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5-11</b> 19 <b>61</b> , and that death occurred at <b>6:05 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Wilber R. Ellis Jr</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>May 13/1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Wilber R. Ellis Jr</b> <b>Dr. David J. Gilmore</b>				22d. ADDRESS <b>Medical Center Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 14, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsonsbury Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Parsonsbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>				25a. REC'D BY REGISTRAR <b>MAY 16 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Hanna</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

Items 18-21 Film 289  
6-23-61  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
6235  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
07376

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN TB <u>1 da.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Seabrook, Del. R.F.D.</u> d. STREET ADDRESS <u>23X-2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Aldean</u> First <u>Williams</u> Middle Last 4. DATE OF DEATH <u>May 29</u> 1961 Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept 27, 1959</u> 9. AGE (In years last birthday) <u>1</u> yrs. <u>1</u> month <u>29</u> days <u>1</u> hour <u>1</u> min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Berlin, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Robert Williams</u> 14. MOTHER'S MAIDEN NAME <u>Francis Showell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Francis Williams Seabrook, Del.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Poisoning</u> 876.0 DUE TO <u>Acute poisoning by ingestion of Strychnine</u> Conditions, if any, which gave rise to immediate cause (b) <u>1 hr.</u> (e), stating the underlying cause first. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ingested mothers low blood pressure tablets</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u> 20f. (City or town) (County) (State) <u>Worc. Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5-29-61</u> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> 22b. DATE THEREOF <u>5/31/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Showell Cemetery</u> 22d. LOCATION (City, town, or country) (State) <u>Showell Md.</u>		23. FUNERAL DIRECTOR <u>Henry L. Watson</u> ADDRESS <u>Pocomoke City, Md.</u> 24a. REC'D BY REGISTRAR <u>JUN 9 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Charles L. Thomas</u>	

STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1907  
REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1906

1907  
JAN 1

1. The Commission has the honor to acknowledge the receipt of your report of the progress of the work of the Land Office during the year 1906. It is gratifying to find that the work has been carried on with great activity and that the results are of a most satisfactory character. The Commission is particularly pleased to find that the work of the Land Office has been carried on in accordance with the plan of action adopted by the Senate in May, 1906, and that the results are of a most satisfactory character. The Commission is particularly pleased to find that the work of the Land Office has been carried on in accordance with the plan of action adopted by the Senate in May, 1906, and that the results are of a most satisfactory character.

2. The Commission is particularly pleased to find that the work of the Land Office has been carried on in accordance with the plan of action adopted by the Senate in May, 1906, and that the results are of a most satisfactory character. The Commission is particularly pleased to find that the work of the Land Office has been carried on in accordance with the plan of action adopted by the Senate in May, 1906, and that the results are of a most satisfactory character.

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5. The Commission is particularly pleased to find that the work of the Land Office has been carried on in accordance with the plan of action adopted by the Senate in May, 1906, and that the results are of a most satisfactory character. The Commission is particularly pleased to find that the work of the Land Office has been carried on in accordance with the plan of action adopted by the Senate in May, 1906, and that the results are of a most satisfactory character.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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6236

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06222

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>3 Wks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>ELIHU</b> Last <b>WILLIAMS</b>		4. DATE OF DEATH Month <b>5</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 3, 1878</b>
9. AGE (In years lost birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel A. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Phippin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-36-0099</b>	
17. INFORMANT <b>Mr. Boyd Williams, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia, Acute</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Osteoporosis - Atherosclerotic Coronary Artery Disease</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 7, 1961</b> to <b>MAY 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>MAY 28, 1961</b> , and that death occurred at <b>10:25 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Thomas C. Hill, Jr.</b>		22b. DATE SIGNED <b>5-29-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas C. Hill</b>		22d. ADDRESS <b>Pine Bluff Rd., Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-31-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 2 '61</b>	
ADDRESS <b>Salisbury, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

*Norman F. Baker*

CERTIFICATE OF BIRTH

238

M

I, the undersigned, being a duly qualified Registrar of Births and Deaths for the District of ... do hereby certify that on the ... day of ... 19... at ... in the County of ... the following named person was born to the wife of ... of the County of ...

Name of Child ...

Sex ...

Age of Mother ...

Signature of Registrar ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

C.M.M.

FOR STATE  
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
06237											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Scott's Camp, Jersey Road</b>				d. STREET ADDRESS <b>Scott's Camp, Jersey Road</b>							
3. NAME OF DECEASED (Type or print) <b>Louis Wood</b>				4. DATE OF DEATH <b>5-6-61</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-16-1909</b>		9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>				11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Not Known</b>				14. MOTHER'S MAIDEN NAME <b>Not Known</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>_____</b>				17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardio-vascular renal disease</b> <b>260 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Earl L. Royer</b> EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b> <b>407 Camden Ave. Salisbury, Md.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>5-8-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>5-8-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Anthonys Bd.</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR <b>Thernton B. Jolley, Salisbury, Md.</b>				24a. REC'D BY REGISTRAR <b>MAY 10 '61</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>			

THE STATE  
DEPARTMENT

(M)

(I)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Locality \_\_\_\_\_  
Residence \_\_\_\_\_  
Occupation \_\_\_\_\_  
Date of Death \_\_\_\_\_  
Time of Death \_\_\_\_\_  
Cause of Death \_\_\_\_\_  
Manner of Death \_\_\_\_\_  
Signature of Medical Examiner \_\_\_\_\_  
Signature of Coroner \_\_\_\_\_  
Signature of Registrar \_\_\_\_\_  
Date of Filing \_\_\_\_\_  
Place of Filing \_\_\_\_\_